

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06691

Item #8 Film #1350 5/19/67 pc

06677

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b 20 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 112 E. Water St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland d. STREET ADDRESS 112 E. Water St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mamie Middle Agnes Last Adams		4. DATE OF DEATH Month May Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889 May 23, 1967
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Home		10b. KIND OF BUSINESS OR INDUSTRY - - -	11. BIRTHPLACE (County & State, or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lemuel Sanders	
14. MOTHER'S MAIDEN NAME Mary Beeman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Margaret Marucci Loch Lynn, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Ischemic Heart Disease (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH mins hrs. hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/7/63 19... to May 1967, that (I) (we) last saw the deceased alive on 3 May 1967, and that death occurred at 2 A.M. from the causes and on the date stated above.			
22a. SIGNATURE B. J. Adams		22b. DATE SIGNED 9 May	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/10/67	23c. NAME OF CEMETERY OR CREMATORY Garrett Co. Mem. Gardens	23d. LOCATION (City, town or county) (State) Oakland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Paul D. Minnick		25a. REC'D BY REGISTRAR MAY 15 1967	
ADDRESS Oakland, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06692

06678

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 16 HRS.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 309 "D" STREET			
3. NAME OF DECEASED (Type or print) First WESLEY Middle CLYDE Last BECKMAN				4. DATE OF DEATH MAY 10 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1967		9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME BECKMAN, FREDDIE CLARENCE				14. MOTHER'S MAIDEN NAME DYE, SYLVIA BEATRICE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address MT. LAKE PARK, MD. F- BECKMAN, FREDDIE CLARENCE -"D" STREET		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Prematurity (1 lb 3 oz) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from MAY 10, 1967 , to MAY 10, 1967 , that (I) (we) last saw the deceased alive on MAY 10, 1967 , and that death occurred on MAY 10, 1967 from causes and on the date stated above.							
22a. SIGNATURE <i>Herbert Leighton</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11 May 67		
22c. PHYSICIAN'S NAME (Type) DR. HERBERT LEIGHTON			22d. ADDRESS OAKLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/67		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cem.		23d. LOCATION (City or Town) (County) (State) Near Oakland, Md.	
24. FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral Home, Oakland, Md.				25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

06693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06679

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 14 hrs. 40 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS BOX # 53	
3. NAME OF DECEASED (Type or print) First NAOMI Middle VIOLA Last BERNARD		4. DATE OF DEATH Month MAY Day 18 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1887
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 18 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) BITTINGER, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AMOS BITTINGER		14. MOTHER'S MAIDEN NAME ELIZABETH BRENNEMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 232-28-6180	
17. INFORMANT (SISTER) MRS. MABEL TIMMERMAN		Address DEER PARK, MARYLAND	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO Arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular disease (c) Arteriosclerotic cardio-vascular disease			INTERVAL BETWEEN ONSET AND DEATH 2 weeks Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compression fracture, L1 4-22-67			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Fall at home 4-22-67.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4-22-67 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Deer Park Garrett Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) JAMES H. FEASTER, JR.		22. DATE SIGNED 5-18-67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/21/67	
23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cem.		23d. LOCATION (City or Town) (County) (State) Near Oakland, Md.	
24. FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral Home, Oakland, Md.		25a. REC'D BY REGISTRAR MAY 22 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06694

CERTIFICATE OF DEATH

06680

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville</u>		c. LENGTH OF STAY IN TB <u>5 Mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville (Rural)</u>		d. STREET ADDRESS <u>447</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Goodwill Mennonite Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Franklin Bittinger</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 22, 1893</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Avilton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Bittinger</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Burkholder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Flossie Bittinger, Grantsville,</u>		Address <u>MD.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic brain syndrome</u> DUE TO (b) <u>Circulatory disturbance</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>0</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)
(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 29, 1966</u> , to <u>May 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1967</u> , and that death occurred at <u>MD.</u> from causes and on the date stated above.		
22a. SIGNATURE <u>G Paige Strong</u>		22b. DATE SIGNED <u>5/9/67</u>
22c. PHYSICIAN'S NAME (Type) <u>G Paige Strong</u>		22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dunst Cemetery</u>
23d. LOCATION (City or Town) <u>Grantsville, Garrett, MD.</u>		(County)
(State)		
24. FUNERAL DIRECTOR <u>Lush Newman</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 15 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

401180

401180



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and 22 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05681

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Oakland		c. LENGTH OF STAY IN 1b 22 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Oakland		d. STREET ADDRESS Star Route	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Star Route		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA ELEANOR BROWNING		4. DATE OF DEATH Month May Day 23 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1890
9. AGE (In years and birth day) 77 yrs.		10. IF UNDER 1 YEAR Months 11 Days 15 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. R.N.		10b. KIND OF BUSINESS OR INDUSTRY Anesthetist	
11. BIRTHPLACE (County & State, or foreign country) Knoxville, Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Mauk		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) Yes WW I		16. SOCIAL SECURITY NO. Herbert W. Browning, Star Rt., Oakland, Md.	
17. INFORMANT (Husband) Herbert W. Browning, Star Rt., Oakland, Md.		Address Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Anteroseptal Cardio Vascular Disease Unknown DUE TO (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1964 to May 23, 1967 , that (I) (we) last saw the deceased alive on May 17, 1967 , and that death occurred at 6:AM , from causes and on the date stated above.			
22a. SIGNATURE Herbert H. Leighton		22b. DATE SIGNED 24 May 67	
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		22d. ADDRESS Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 26, 1967	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City or Town) (County) (State) Oakland, Garr. Md.	
24. FUNERAL DIRECTOR John O. Durst		25a. REC'D BY REGISTRAR MAY 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

26696

06682

1. PLACE OF DEATH
a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Oakland

c. LENGTH OF STAY IN 1b

1 hr.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if first tuition, Residence before admission)

a. STATE

Maryland

b. COUNTY

Garrett

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Loch Lynn

d. STREET ADDRESS

211 Dundee St.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Edward

Middle

Ellsworth

Last

Callis

4. DATE OF DEATH

Month

May

Day

20

Year

1967

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

July 4, 1918

9. AGE (In years) F UNDER 1 YEAR IF UNDER 24 HRS

48 yrs

Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman

10b. KIND OF BUSINESS OR INDUSTRY

Gas Co.

11. BIRTHPLACE (County & State or foreign country)

Loch Lynn, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Callis

14. MOTHER'S MAIDEN NAME

Celia Sturn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

yes

WW 2

16. SOCIAL SECURITY NO

212-12-8400

17. INFORMANT

Mrs. Audra Callis

Address

see #2 above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

5-10 yrs

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)

20f. City or town

County

State

21. I certify that (I) (this hospital) attended the deceased from 1966 to 21 May 1967, that (I) (we) last saw the deceased alive on 21 May 1967, and that death occurred at 5 p.m. from the causes and on the date stated above.

22a. SIGNATURE

A. F. Mance

M.D.

ATTENDING PHYS ☒

MED. DIRECTOR ☐

STAFF PHYS ☐

22b. DATE SIGNED

21 May 1967

22c. PHYSICIAN'S NAME (Type)

A. F. Mance

22d. ADDRESS

Oakland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

15/23/67

23c. NAME OF CEMETERY OR CREMATORY

Garrett Co. Mem. Gardens Oakland, Maryland

23d. LOCATION (City, town or county)

State

24. FUNERAL DIRECTOR'S SIGNATURE

Gerald Minnich

ADDRESS

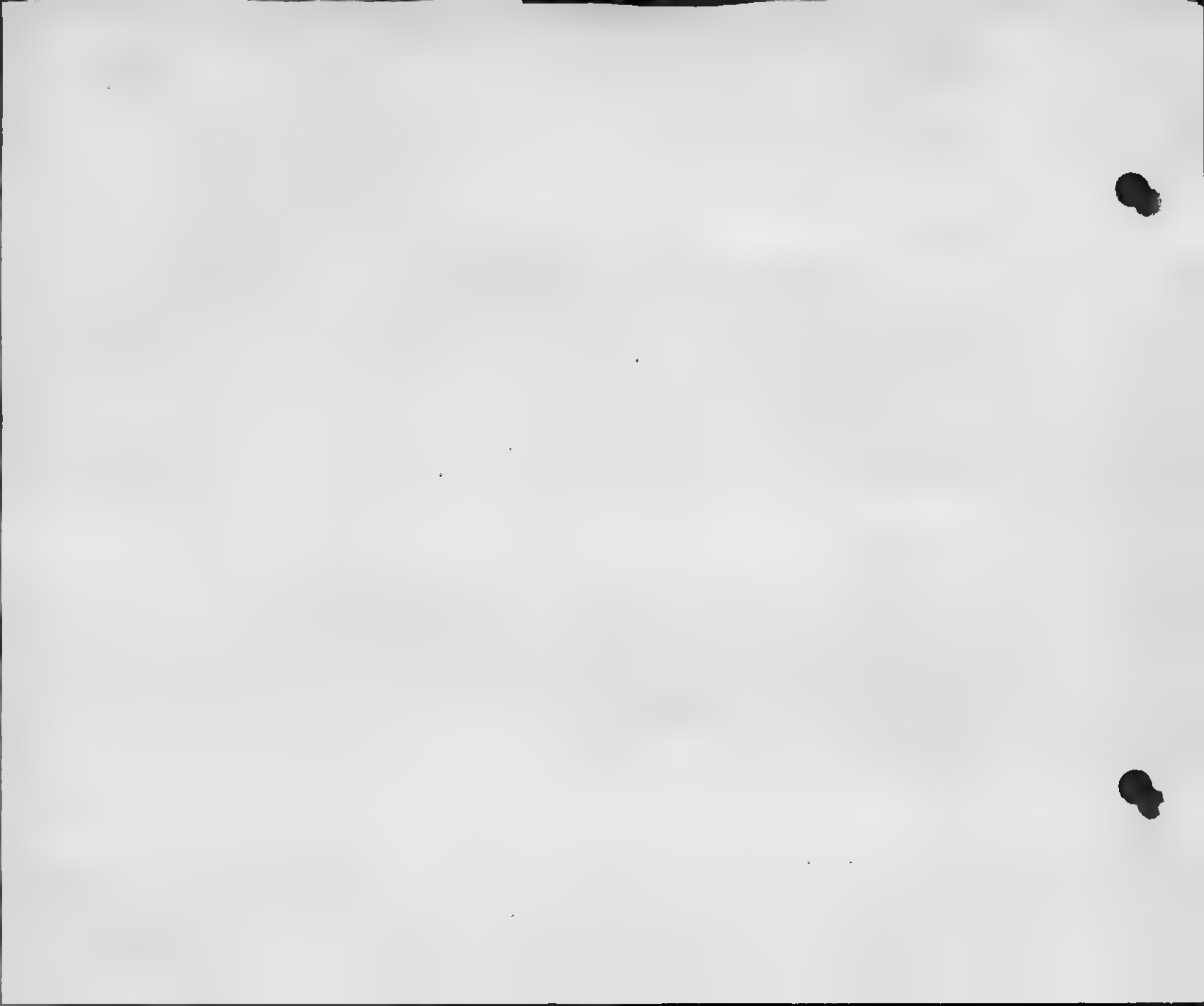
Oakland, Maryland

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUN 2 1967

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

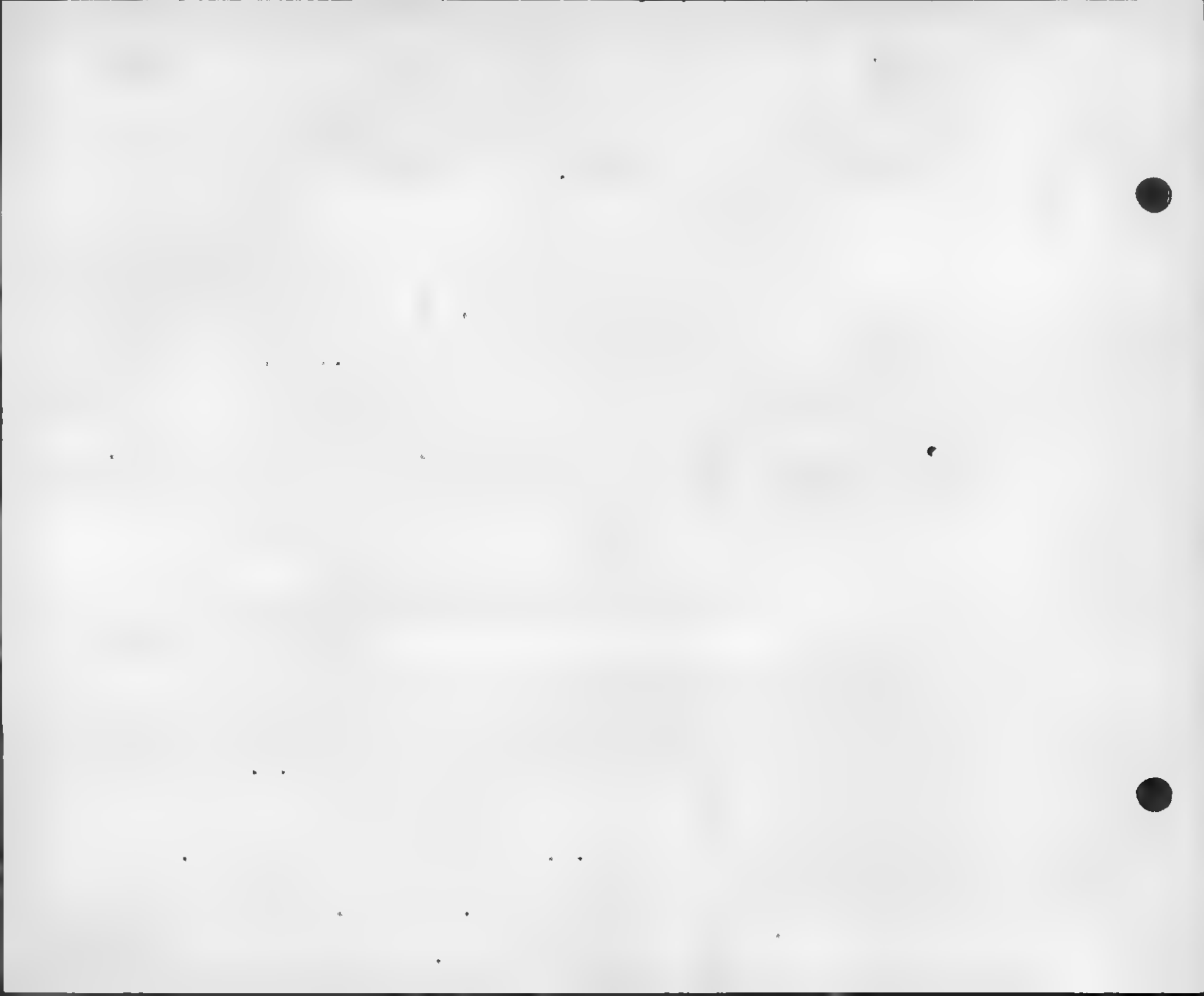
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06697

06683

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident		c. LENGTH OF STAY N. b. 50 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last OMA BLANCHE CUSTER		4. DATE OF DEATH Month Day Year May 15, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1890
9. AGE (in years last birthday) yrs 77		10. IF UNDER 1 YEAR Months Days Hours Min 19 67	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. K.IND OF BUSINESS OR INDUSTRY Own home	
13. BIRTHPLACE (Country & State or foreign country) Garrett Co., Md.		14. CIT ZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Jonas Weitzell		16. MOTHER'S MAIDEN NAME Ellen Sigler	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO	
19. INFORMANT Thomas S. Custer, Accident, Md.		Address (Husband)	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary occlusion DUE TO (b) Diabetes Mellitus DUE TO (c) Generalized arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , to May 15, 1967 , that (I) (we) last saw the deceased alive on May 15, 1967 , and that death occurred at 7:10 P.M. causes and on the date stated above			
22a. SIGNATURE Harold O. Kamons		22b. DATE SIGNED May 17, 1967	
22c. PHYSICIAN'S NAME (Type) Harold O. Kamons, M.D.		22d. ADDRESS Markleysburg, Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
Burial	5/20/67	St. Paul's Luth. Ch. Cem.	Accident, Maryland
24. FUNERAL DIRECTOR John O. Durst		25a. REC'D BY REGISTRAR John O. Durst	
25b. REGISTRAR'S SIGNATURE Leighton-Durst Funeral Home, Oakland, Md.		DATE MAY 22 1967	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

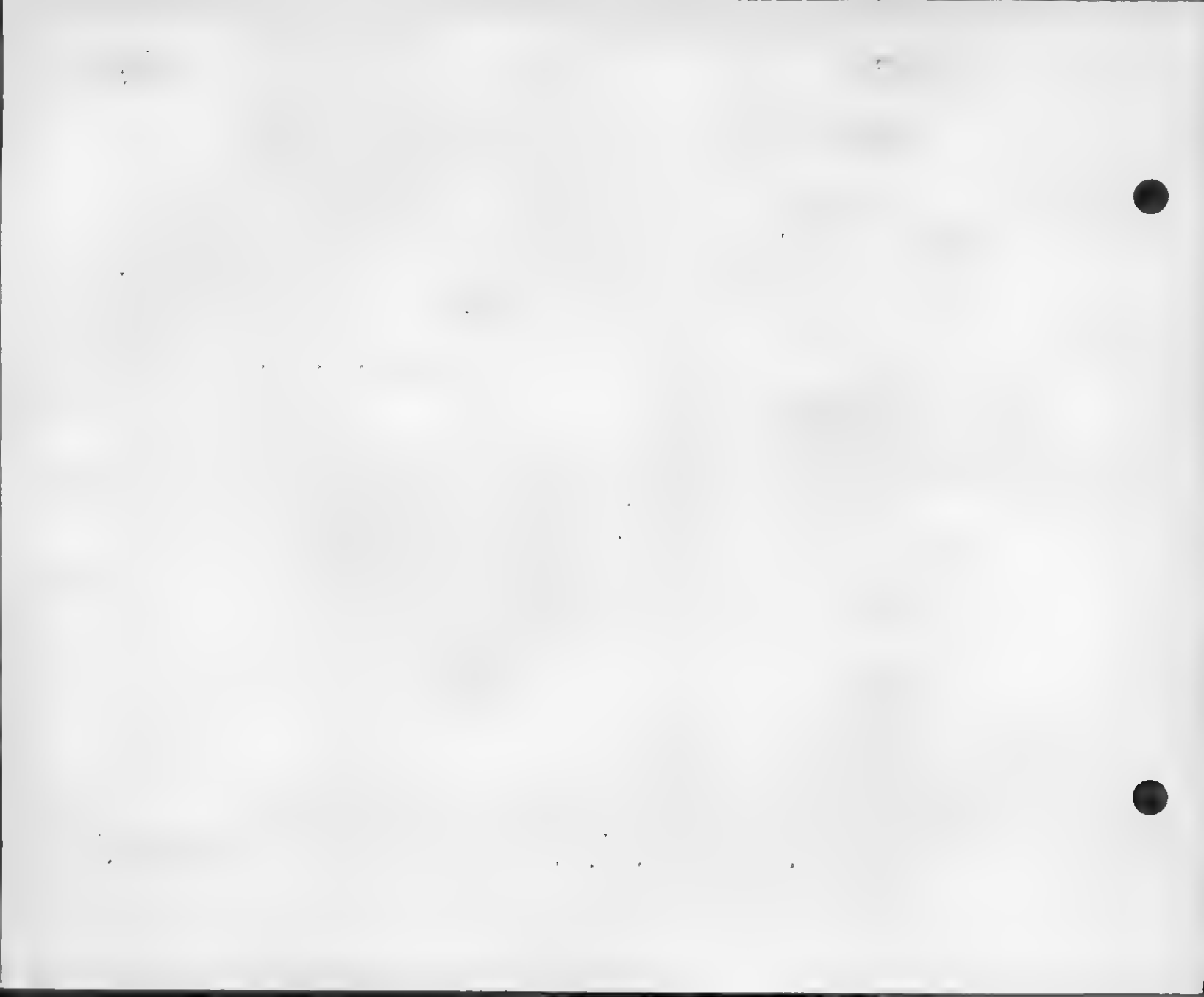
VR A15ME (5)
6M 1/67

06698

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06684

1 PLACE OF DEATH a COUNTY Garrett		2 USUAL RESIDENCE (Where deceased lived, if different from a STATE Maryland b COUNTY Garrett	
c CITY OR TOWN (If outside county write RURAL and give nearest town) Oakland		d LENGTH OF STAY IN c Minutes	
e NAME OF HOME (If not in hospital give street address) (DOA) Garrett Co. Memorial Hospital		f STREET ADDRESS Star Route	
3 NAME OF DECEASED Type or print, James Arthur Deem		4 DATE OF DEATH May 28th 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-8-04
9 AGE 62		10 SEX Male	
11a OCCUPATION (work if work done during most of working life even if retired) Miner		11b KIND OF BUSINESS OR INDUSTRY Coal	
12 BIRTHPLACE state foreign Fairfax, W. Va.		13 COUNTRY USA	
14 FATHER'S NAME Van Deem		15 MOTHER'S MAIDEN NAME Blanche Trembly	
16 WAS DECEASED EVER IN ARMED FORCES? (Yes no or unknown) no		17 SOCIAL SECURITY NO 219-18-7077	
18 CAUSE OF DEATH (Enter cause per item 18a and 18b) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia, terminal DUE TO Arterio-sclerotic hypertensive cardio-vascular disease DUE TO vascular disease PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISORDER (b) see # 2 above		19 INTER-VALENCE PERIOD 10 31/2	
20a EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (nature of injury, extent or part of body affected)	
21a I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22 DATE SIGNED 5-28-67	
23 ACTUAL SIGNATURE James H. Feaster, Jr., M.D.		24 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
25 EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		26 ADDRESS Oakland, Md.	
27a BURIAL CREMATION Burial	27b DATE THEREOF 5/31/67	28 NAME OF CEMETERY OR REPOSITORY Deer Park Cemetery	
29 ADDRESS Oakland, Maryland		30 RECORD BY REGISTRAR JUN 2 1967	
31 FUNERAL DIRECTOR Walden L. Linnich		32 REGISTRAR'S SIGNATURE Walden L. Linnich	



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MARYLAND STATE DEPARTMENT OF HEALTH

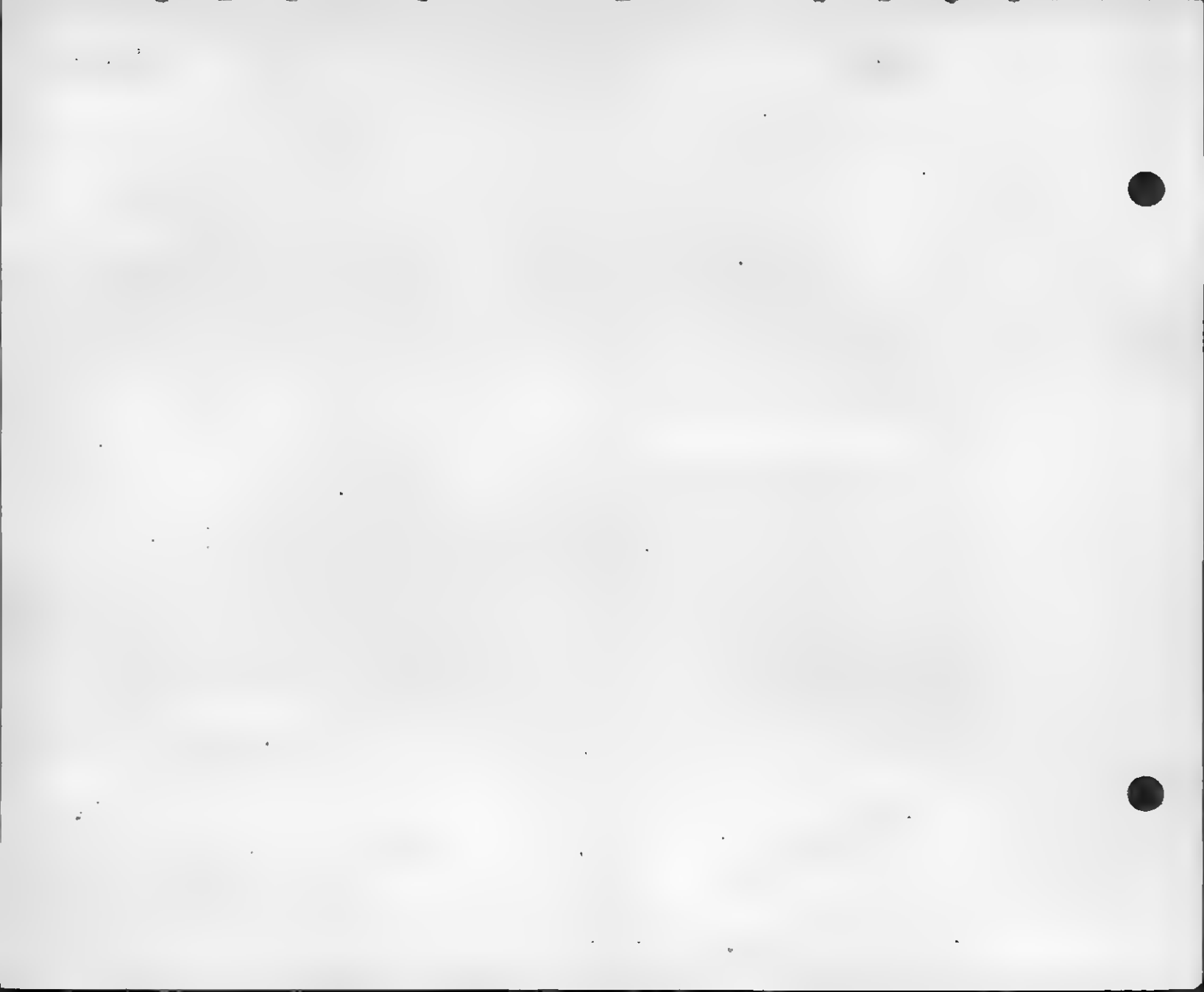
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06693

06685

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garret</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>133</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>133</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year <u>19</u>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Garrett County, Md.</u>			
13. FATHER'S NAME <u>William Myers</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Fife</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
<u>No</u>		<u>--</u>		<u>Mrs. Joryle VanSickle</u>		<u>133</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 yr.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> , 19 <u>67</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ross Rumbaut M.D.</u>				22b. DATE SIGNED <u>5-29-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ross Rumbaut M.D.</u>				22d. ADDRESS <u>Myersdale, PA</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sand Spring Cem.</u>		23d. LOCATION (City, town or county) (State) <u>rusvill, Garrett, Md.</u>	
24. FUNERAL DIRECTOR <u>Rich Thurman</u>				25a. REC'D BY REGISTRAR <u>11:11</u> DATE <u>19:7</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	



06700

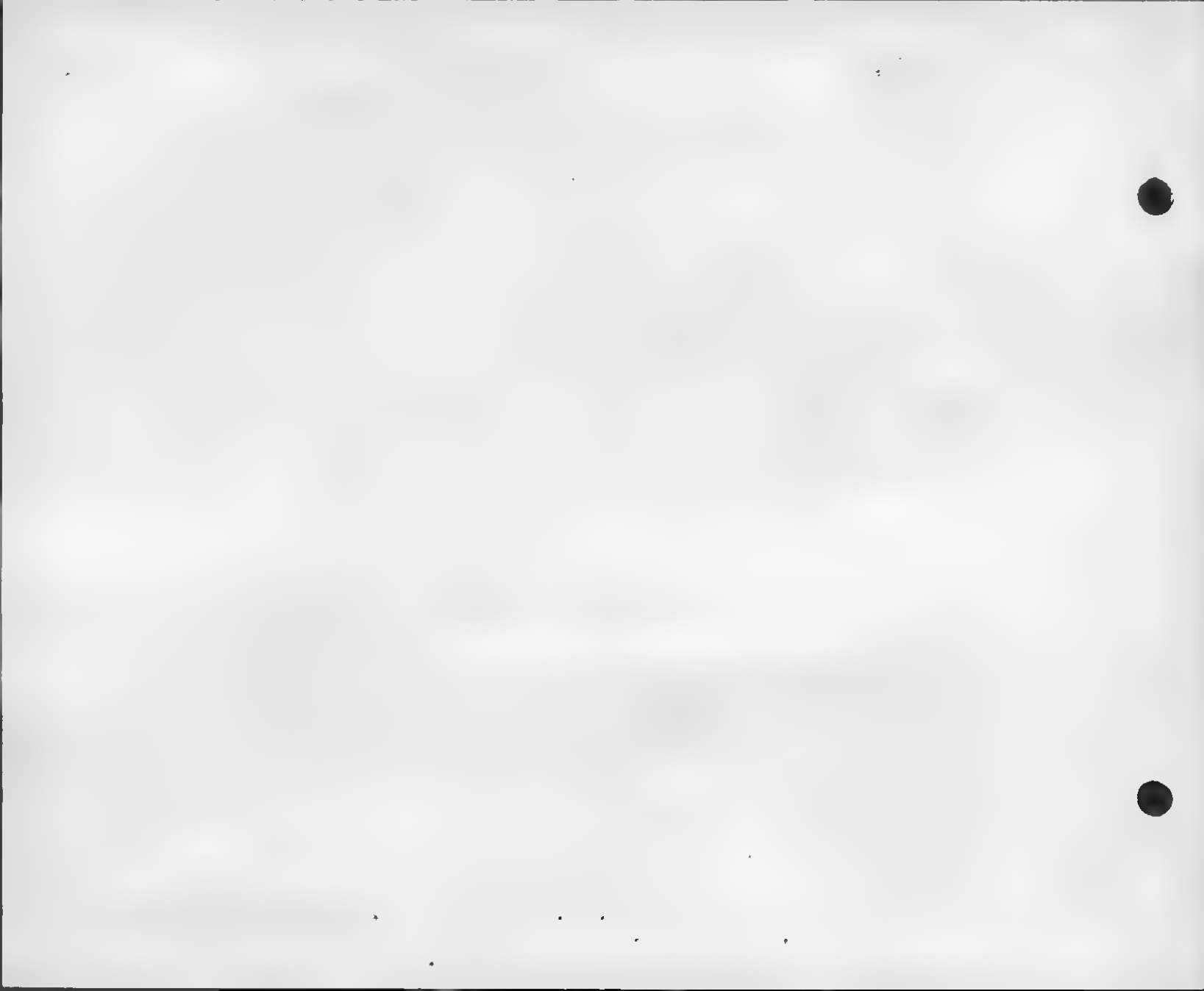
CERTIFICATE OF DEATH

06686

1 PLACE OF DEATH a COUNTY Garrett MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 20 Hrs. 5 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				d. STREET ADDRESS 5 W. Third St.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last LETH STIGLIE IMHOFF				4 DATE OF DEATH Month Day Year May 30 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 7, 1941		9 AGE (in years last birthday) yrs. 26	10 UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Auto Ser. Stat.		11 BIRTHPLACE (County & State or foreign country) Meyersdale, Pa.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Elwood IMHOFF				14. MOTHER'S MAIDEN NAME Vella Isabel IMHOFF			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) Yes 1960		16 SOCIAL SECURITY NO 163-32-0517		17 INFORMANT Mother Address Mt. Lake Park, Maryland			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PERICARDIOMYOLYSIS 11/4/66 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DEGENERATIVE CARDIOVASCULAR CHANGES DUE TO (c) BARBITURATE POISONING & SUB-MARINE DROWNING						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 weeks						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or, Part II of item 18) 11/4/66					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Apr 3 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 11/4/66		20f. (City or town) (County) (State) 11/4/66	
21. I certify that (I) (this hospital) attended the deceased from May 29, 1967, to May 30, 1967 , that (I) (we) last saw the deceased alive on May 30, 1967 , and that death occurred at 12:55 PM from causes and on the date stated above							
22a. SIGNATURE E. I. Baumgartner				22b. DATE SIGNED 5/30/67		22c. PHYSICIAN'S NAME (Type) Dr. E. I. Baumgartner	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 2, 67		23c. NAME OF CEMETERY OR CREMATORY Garr. Co. Memorial Gar.		23d. LOCATION (City or Town) (County) (State) Oakland, Maryland	
24 FUNERAL DIRECTOR John O. Durst				25a. REC'D BY REGISTRAR John E. Durst		25b. REGISTRAR'S SIGNATURE John E. Durst	
26 FUNERAL HOME Leighton-Durst Funeral Home, Oakland, Md.				DATE JUN 2 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

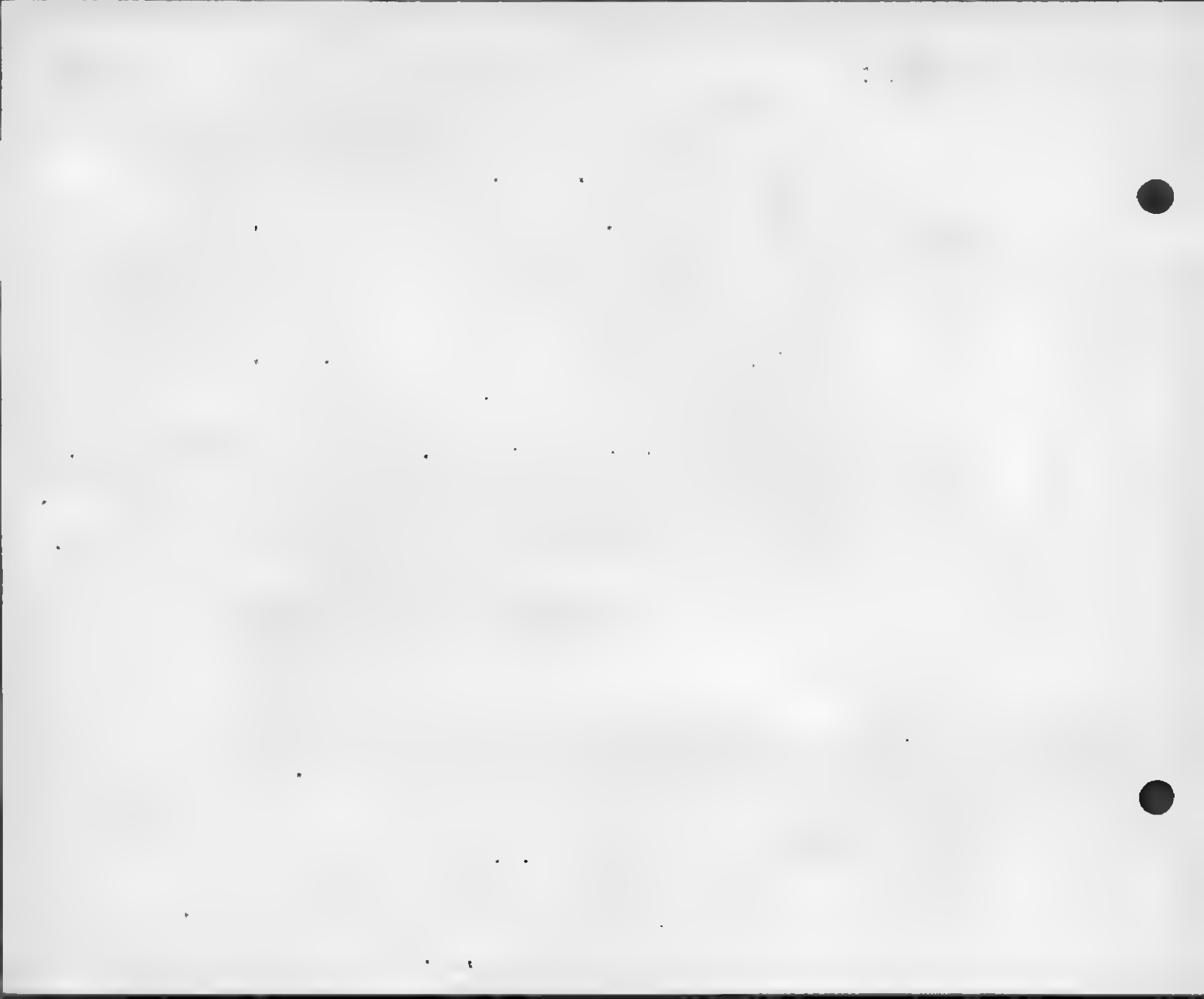
MD. STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

06701

06687

1 PLACE OF DEATH a COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c LENGTH OF STAY N 1b 38 hr. 7min. Oakland	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Memorial Hosp.		d STREET ADDRESS 317 E. Oak St.	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) HERBERT First CALE Middle LEIGHTON Last		4 DATE OF DEATH Month May Day 19 Year 1967	
5 SEX Male	6 CO. OR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar. 22, 1899
9 AGE (in years last birthday) 68 yrs		10 UNDER 24 HRS Months 19 Days 67 Hours 19 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Funeral Dir.		10b KIND OF BUSINESS OR INDUSTRY Funeral	
11 BIRTHPLACE (Country & State or foreign country) Garrett Co., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Herbert V. Leighton		14 MOTHER'S MAIDEN NAME Mary Maude Cal.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213-12-2962	
17 INFORMANT (Widow)		Address Mrs. H.C. Leighton, Oakland, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic coronary artery disease yrs. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (F EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1948 to 5-19-67 , 19__, that (I) (we) lost saw the deceased alive on 5-18-67 19__ and that death occurred at 5:15 A.M. from causes and on the date stated above			
22a SIGNATURE James H. Feaster, Jr. M.D.		22b DATE SIGNED 5-19-67	
22c PHYSICIAN'S NAME (Type) James H. Feaster, Jr. M.D.		22d ADDRESS Oakland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/22/67	
23c NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d LOCATION (City or Town) (County) (State) Oakland, Md.	
24 FUNERAL DIRECTOR John O. Durst		25a REC'D BY REGISTRAR MAY 23 1967	
25b REGISTRAR'S SIGNATURE James Judge			



FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06688

06702

PLACE OF DEATH

a. CITY

MARYLAND

2. USUAL RESIDENCE

a. STATE

NTY

CITY OR TOWN (If not, specify write RURAL and give nearest town)

Grantsville

1. LENGTH OF STAY

Years

CITY OR TOWN (If not, specify write RURAL and give nearest town)

Grantsville

d. NAME OF HOSPITAL OR INSTITUTION (If not, give street address)

d. STREET ADDRESS

3. NAME OF DECEASED (Type or print)

William Harold Miller

4. DATE OF DEATH

May 10, 1957

5. SEX

6. COLOR OR RACE

MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (last birthday)

Months Days Hours Min

10. USUAL OCCUPATION (If not, give kind of work done during most of working life ever frequented)

11. KIND OF BUSINESS OR INDUSTRY

1. BIRTHPLACE (State or foreign country)

12. ETHNICITY OF WHAT COUNTRY

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter in Part I or Part II)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Myocardial Infarction

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

19. DUE TO

Arteriosclerosis, Generalized

20. DUE TO

(c)

19. RIVAL REPLY ON DEATH

YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

21. EXTERNAL CAUSE OF DEATH (PRIMARY or SECONDARY CAUSE OF DEATH)

22. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

23. TIME OF DEATH (Month Day Year)

19

24. WHERE OCCURRED

25. PLACE OF INJURY (If not, specify factory, street, household, etc.)

26. PLACE OF INJURY (If not, specify factory, street, household, etc.)

27. I certify that took charge of the remains described above held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type or print)

JAMES H. FLASTER, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address Street city town or county State

22. DATE SIGNED

5/16/57

23. PRIOR CREMATION REMOVAL (Specify)

24. DATE THEREOF

25. NAME OF CEMETERY OR CREMATORY

Grantsville

26. FUNERAL DIRECTOR

ADDRESS

Grantville, Md.

27a. RECEIVED BY REGISTRAR

DATE MAY 22 1967

27b. REGISTRAR SIGNATURE

Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate while the ward pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

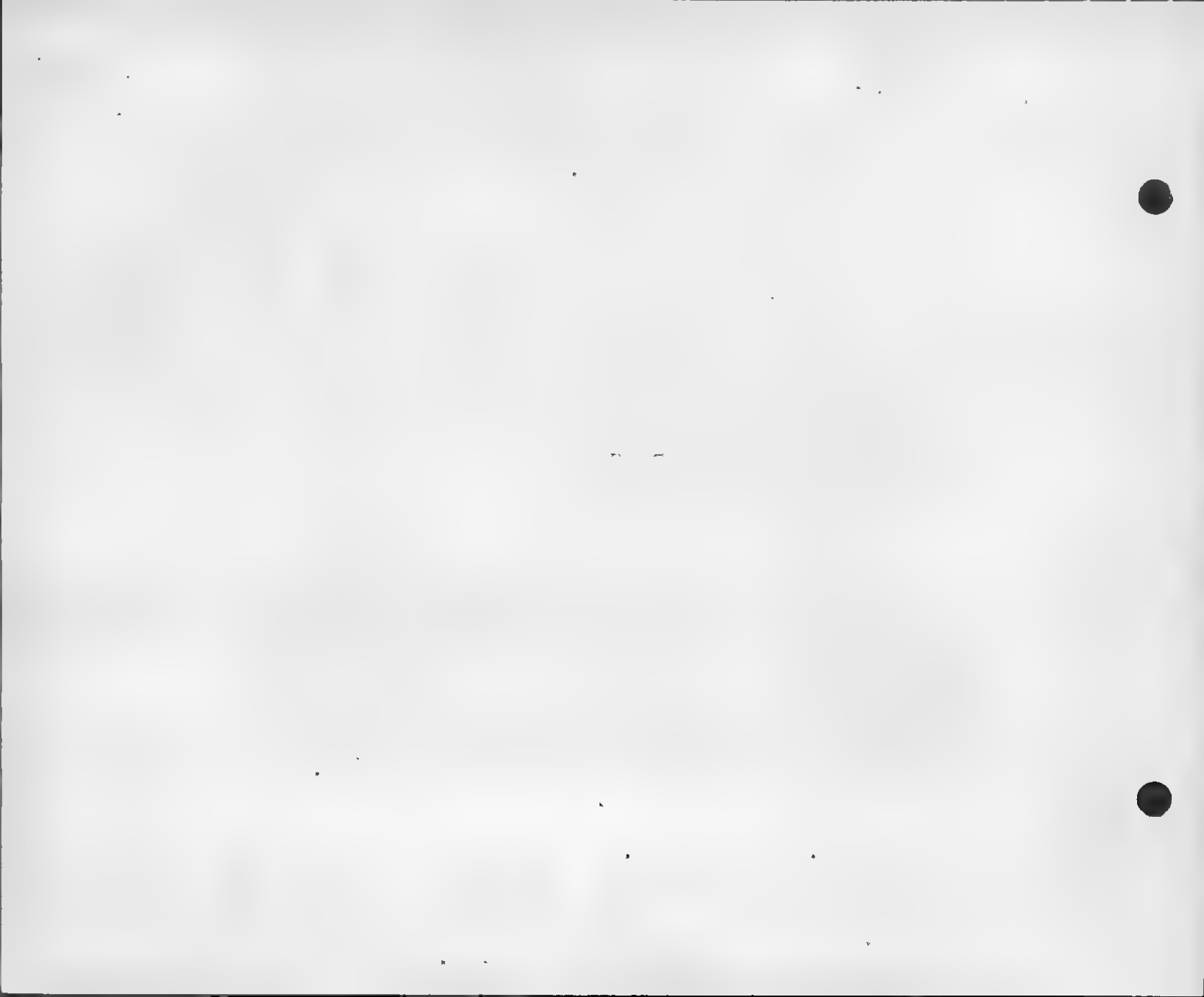
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06703

CERTIFICATE OF DEATH

06689

1 PLACE OF DEATH a COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Allegheny c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c LENGTH OF STAY IN 1b 2 yrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oak Rest Nursing Home		d STREET ADDRESS 405 Woodlawn Terrace	
3 NAME OF DECEASED (Type or print) JAMES K MITCHELL		4 DATE OF DEATH May 15, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct 27, 1898
9 AGE (in years last birthday) 68 yrs		10 IF UNDER 1 YEAR Months Days Hours IF UNDER 24 HRS Months Days Hours	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTH-PLACE (County & State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 214-07-2810	
17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Myocardial Infarction DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH Day
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/6, 1965 , to 5/15, 1967 , that (I) (we) last saw the deceased alive on 5/9, 1967 , and that death occurred at 6 A.M. from causes and on the date stated above.			
22a SIGNATURE B. L. Grant, M.D.		22b DATE SIGNED May 15, 1967	
22c PHYSICIAN'S NAME (Type) B. L. Grant, M.D.		22d ADDRESS Oakland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Buried	23b DATE THEREOF 5/18/67	23c NAME OF CEMETERY OR CREMATORY Reformed Church Cem.	23d LOCATION (City or Town) (County) (State) Meyersdale, Somerset, Pa.
24 FUNERAL DIRECTOR John O. Durst		25a REC'D BY REGISTRAR May 22 1967	25b REGISTRAR'S SIGNATURE John O. Durst



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

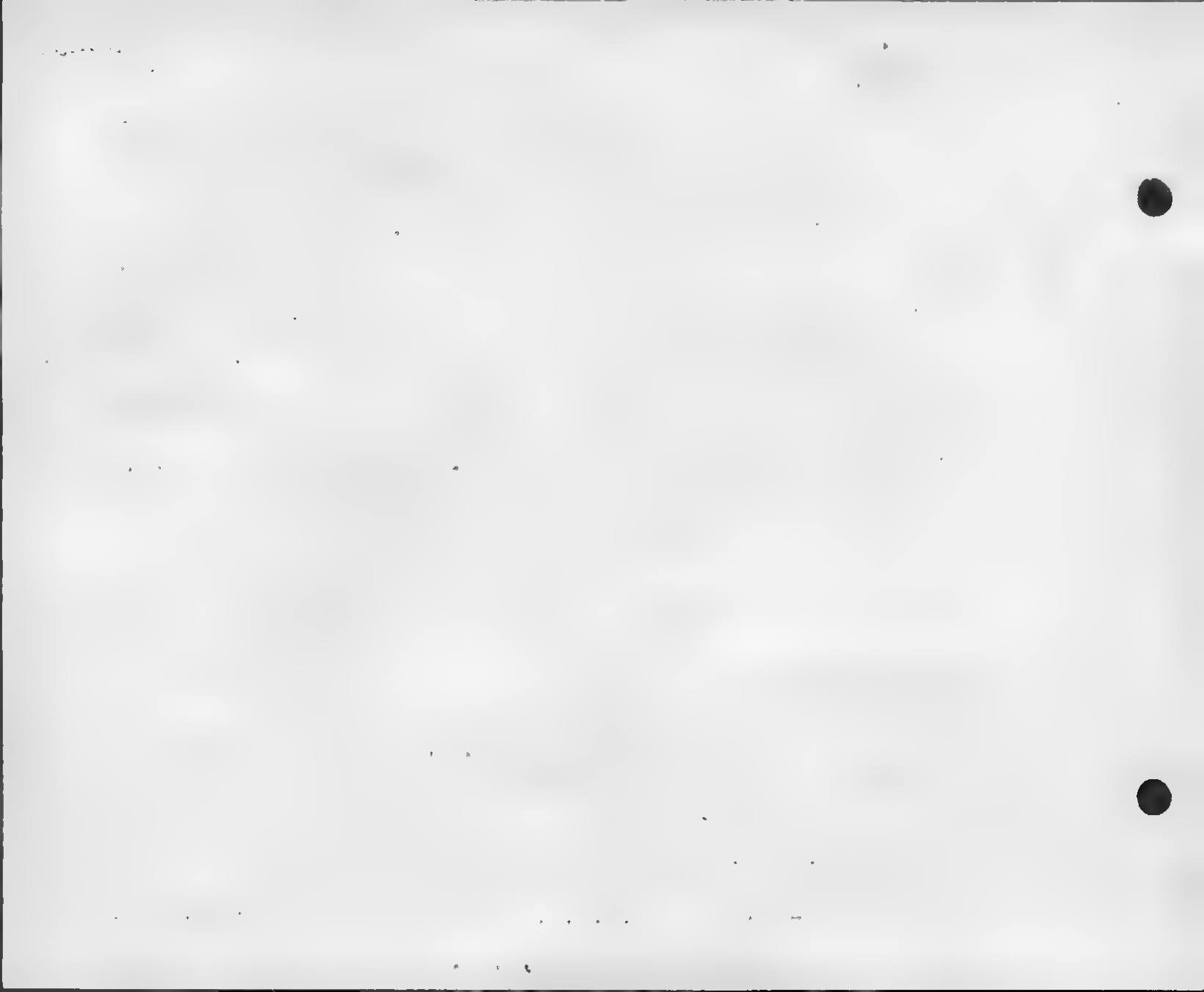
1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05690

1 PLACE OF DEATH a COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE West Virginia b COUNTY Mineral	
b CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) Oakland		c LENGTH OF STAY N 1b 2 days-17 hrs	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett County Memorial Hospital		d STREET ADDRESS 208 N. Main	
3 NAME OF DECEASED (Type or print) Sadie Rudolph		4 DATE OF DEATH Month May Day 15 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Month August Day 31 Year 1876
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Wife		10b KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State, or foreign country) Burlington, West Va.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME William Taylor		14 MOTHER'S MAIDEN NAME Sarah Kuykendall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Arthur Slocum, Keyser, W. Va.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) hypertension DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 31, 1966 to May 15, 1967 , that (I) (we) last saw the deceased alive on May 15, 1967 , and that death occurred at 4:30 AM from causes and on the date stated above			
22a SIGNATURE B. L. Grant		22b DATE SIGNED May 17	
22c PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d ADDRESS Oakland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5-17-67	
23c NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		23d LOCATION (City or Town) (County) (State) Elk Garden, W. Va.	
24 FUNERAL DIRECTOR Thomas Smith		25a REC'D BY REGISTRAR DATE MAY 17 1967	
25b REGISTRAR'S SIGNATURE O. Charles Sledge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05691

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>36 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Star Route</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> d. STREET ADDRESS <u>Star Route</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Edith Railey</u>				4. DATE OF DEATH Month Day Year <u>May 25 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 7, 1892</u>	
9. AGE (In years last birthday) <u>74 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State or foreign country) <u>Avilton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Merrill</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beeghly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Earle Railey</u> 17. INFORMANT <u>Star Route Oakland, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Congestive Failure</u> (c) <u>Advanced Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, County, State)	
21. I certify that (I) (Name of informant) attended the deceased from 5/24 1967, to 5/25 1967, that (I) (Name of informant) saw the deceased alive on 5/24 1967, and that death occurred at 11:10 a.m. from the causes and on the date stated above.							
22a. SIGNATURE <u>E. I. Baumgartner</u>				22b. DATE SIGNED <u>5/27/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. I. Baumgartner M.D.</u>				22d. ADDRESS <u>Oakland, Maryland</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garrett Co. Mem. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Oakland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				25a. REC'D BY REGISTRAR <u>100</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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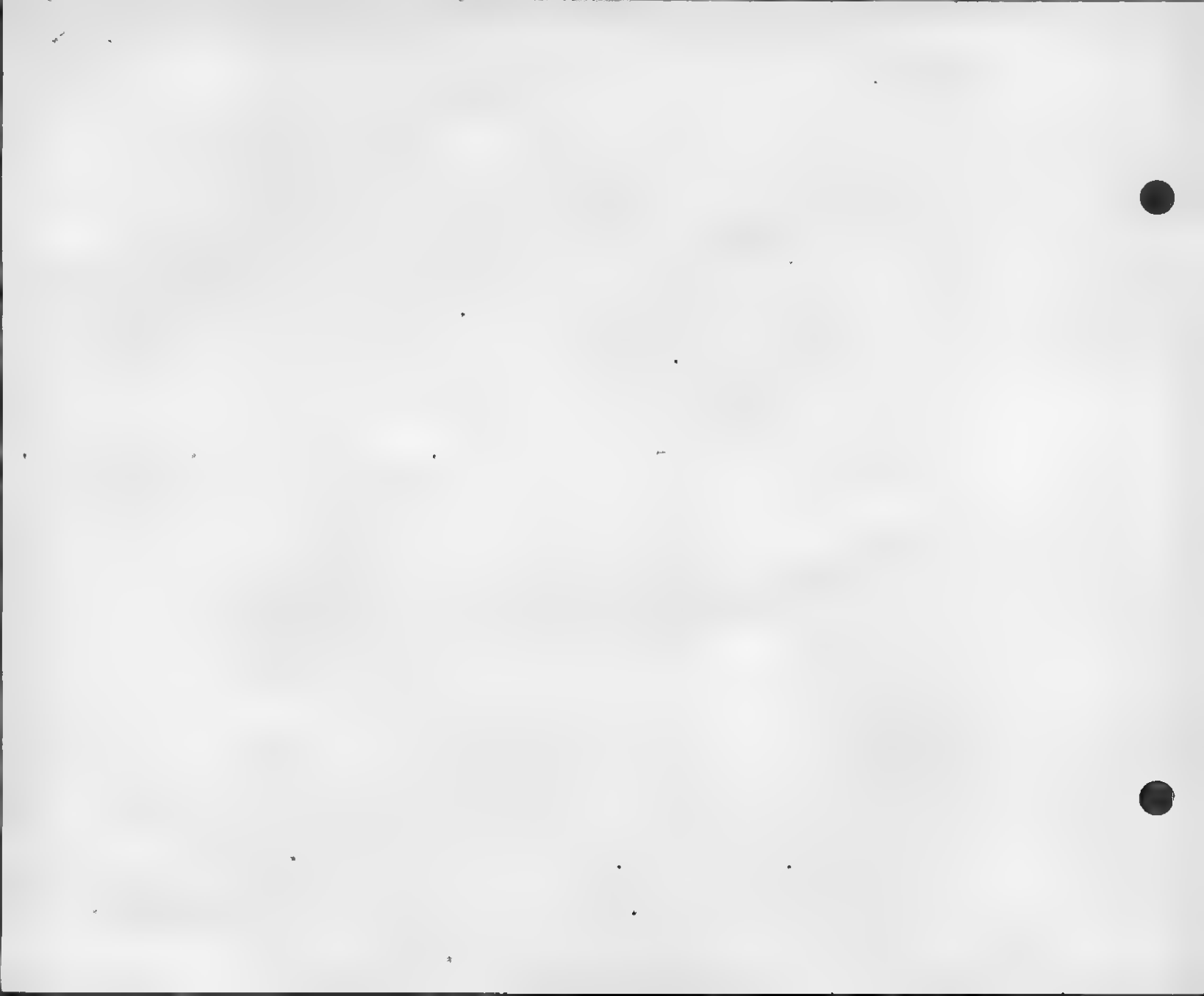
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

26706

CERTIFICATE OF DEATH

05692

1. PLACE OF DEATH a COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if first list on Residence before admission) a STATE Maryland b COUNTY Garrett	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Oakland		c LENGTH OF STAY IN TB Lifetime	
c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Oakland		d STREET ADDRESS Rt #2, Box #138	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #2, Box #138		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CHARLES WALTER LEE SOELTER		4 DATE OF DEATH April 7, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 12, 1889
9 AGE (In years last birthday) 77 yts		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b KIND OF BUSINESS OR INDUSTRY Gen. Farming	
11 BIRTHPLACE (County & State, or foreign country) Garrett Co., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Henry Lewis Soelter		14 MOTHER'S MAIDEN NAME Mary Lidia Martin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 215-26-7057A	
17 INFORMANT Mrs. C. W. Soelter, Rd2, Oakland, Md.		Address (Widow)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Ischemic Heart Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 hrs 40'	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 4, 1966 to May 1, 1967 , that (I) (we) last saw the deceased alive on 29 Apr 1967 , and that death occurred at 11:45 A.M. from causes and on the date stated above			
22a SIGNATURE B.L. Grant		22b DATE SIGNED 5/8/67	
22c PHYSICIAN'S NAME (Type) B.L. Grant, M.D.		22d ADDRESS Oakland, Md.	
23a BURIAL, CREMATION, REMOVAL (Type) Burial	23b DATE THEREOF 5/9/67	23c NAME OF CEMETERY OR CREMATORY St. John's Lutheran Cem.	23d LOCATION (City or Town) (County) (State) Near, Oakland, Md.
24 FUNERAL DIRECTOR John O. Durst		25a REC'D BY REGISTRAR John O. Durst	25b REGISTRAR'S SIGNATURE Michaelas Judge
Leighton-Durst Funeral Home, Oakland, Md.		DATE MAY 10 1967	



26707

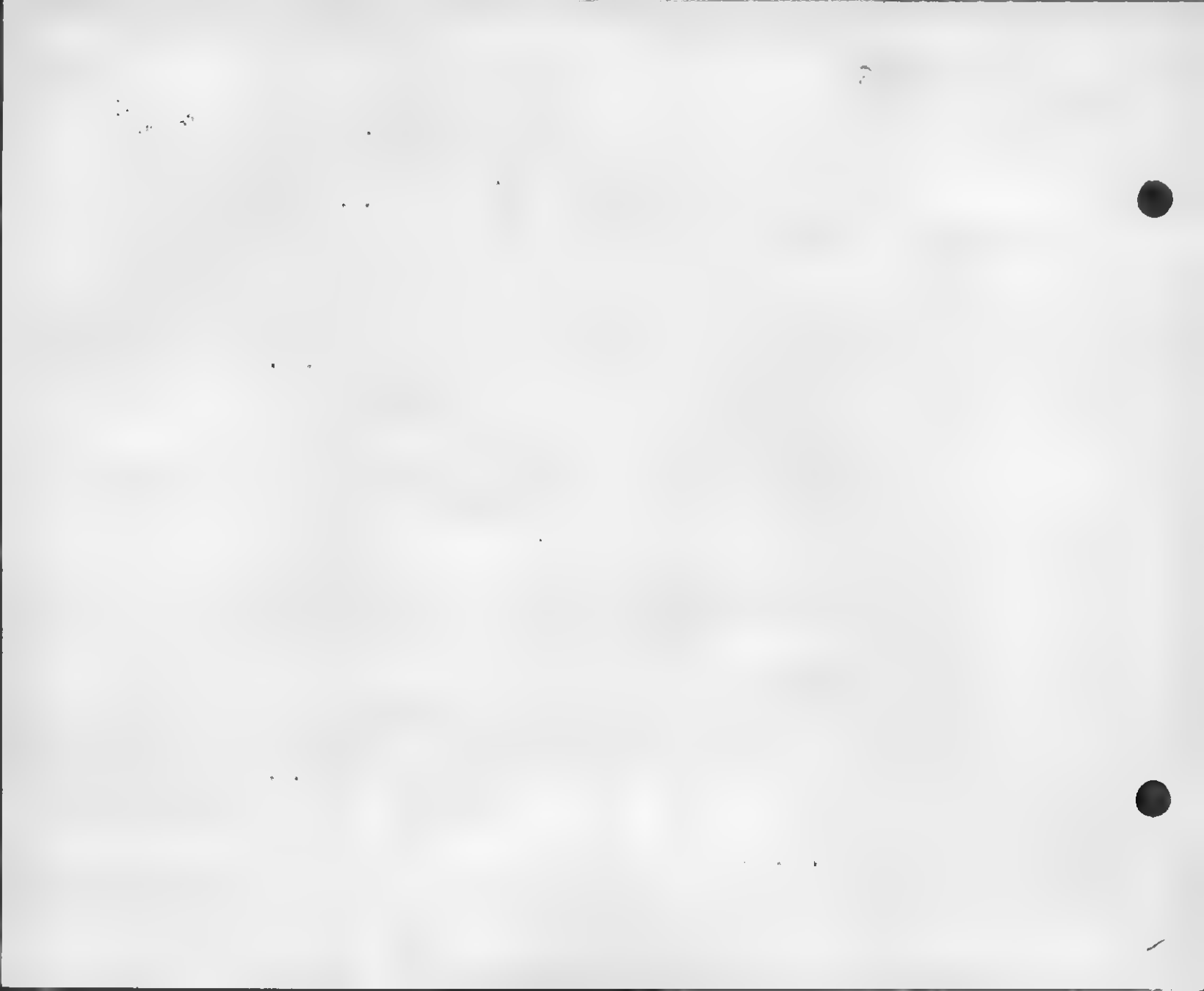
CERTIFICATE OF DEATH

05693

1 PLACE OF DEATH a. COUNTY		Garrett		MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Oakland		c LENGTH OF STAY In b	
		19 days 13 hr.		Terra Alta	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Garrett County Memorial Hospital		e STREET ADDRESS	
				P.O. Box 242 201 State Street	
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)		First Middle Last		4 DATE OF DEATH	
Ira Lee Stahl				Month Day Year	
				May 3 1967	
5 SEX		6 CO. OR OR RACE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Male White				8 DATE OF BIRTH	
				December 14, 1895	
10a OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country)	
				Mannington, W.Va.	
3 FATHER'S NAME		Franklin Stahl		12 CITIZEN OF WHAT COUNTRY?	
				America	
13 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT Address	
Yes WWI		234-32-2285		Floyd L. Stahl Armington, Va	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c)		Interval between onset and death 3 days 2 days 7 hours			
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19				20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 27, 1966, to May 3, 1967, that (I) (we) last saw the deceased alive on May 3, 1967, and that death occurred at 10:55 P.M. on causes and on the date stated above					
22a SIGNATURE		MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED	
Dr. A. E. Mance				3/11/67	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS			
		Oakland, Maryland			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY	
Burial		5-1-67		St. John's Cemetery, Oakland, Md.	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR MAY 8 1967	
Charles Judge				25b REGISTRAR'S SIGNATURE	
				Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

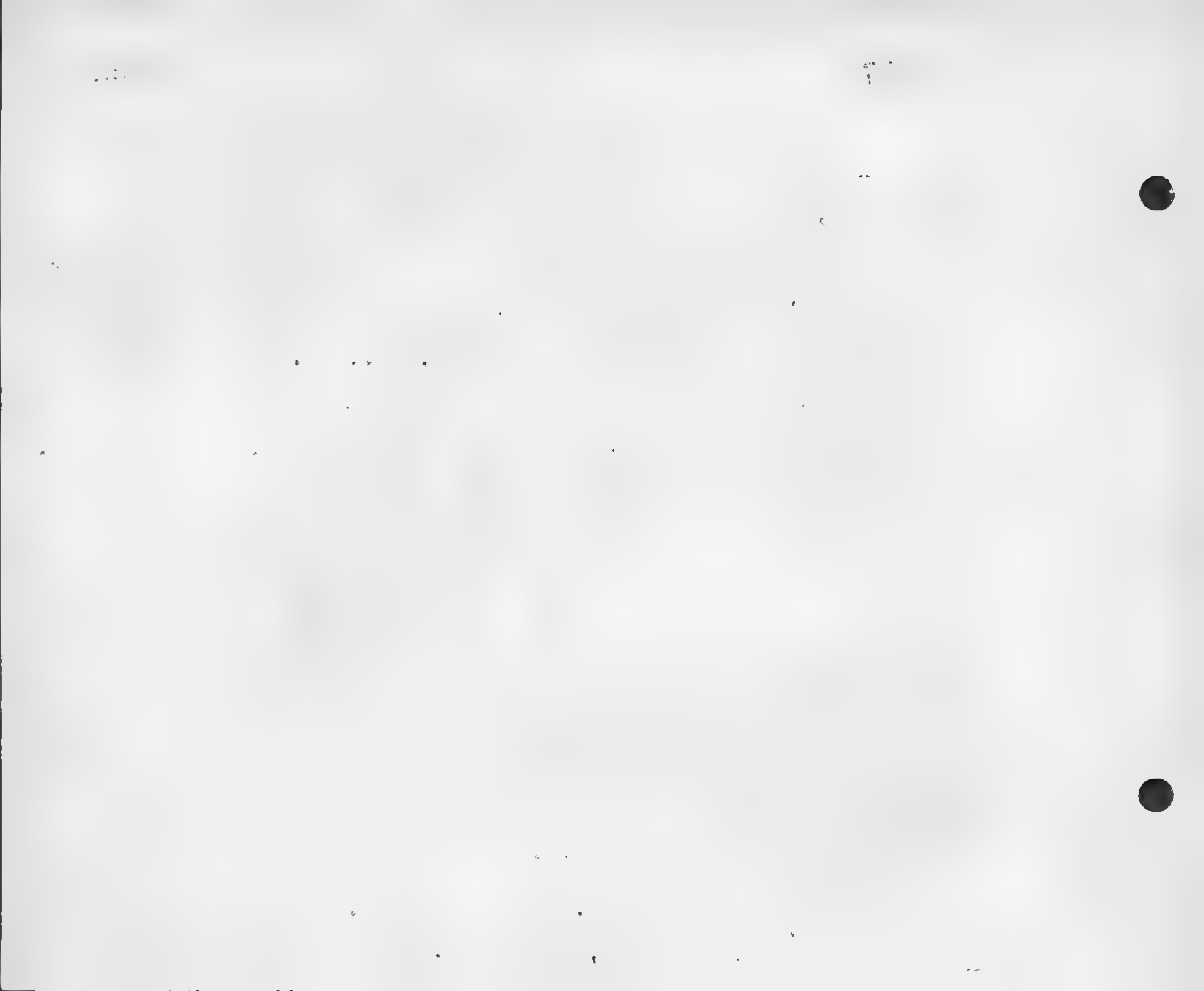
06708

06694

1 PLACE OF DEATH a COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Rural - Deer Park		c. LENGTH OF STAY IN 1b 21 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #1,		e. STREET ADDRESS Route #1	
3 NAME OF DECEASED (Type or print) MYRTLE MARIE STEYER		4 DATE OF DEATH Month May Day 2 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan 26, 1918
9 AGE (In years last birthday) 49 yrs		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY County Court	
11 BIRTHPLACE (County & State or foreign country) Garr. Co., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Henry Gauer		14 MOTHER'S MAIDEN NAME Garnie Bittinger	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 219-01-6694	
17 INFORMANT Keith Steyer, Rt #1, Deer Park, Md.		Address (Husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE GENERALIZED CARCINOMA DUE TO (b) PRIMARY CARCINOMA RIGHT BREAST DUE TO (c) 5 yrs.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (th s hospita) attended the deceased from 12/1/45 , 19____, to 5/2/67 , 19____, that (I) (we) last saw the deceased alive on Apr 10 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.			
22a SIGNATURE E. I. Baumgartner		22b DATE SIGNED 5/4/67	
22c PHYSICIAN'S NAME (Type) E. I. Baumgartner, M.D.		22d ADDRESS Oakland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF May 5, 1967	23c NAME OF CEMETERY OR CREMATORY Garr. Co. Memorial Gar.	23d LOCATION (City or Town) (County) (State) Oakland, Maryland
24 FUNERAL DIRECTOR John O. Durst		25a REC'D BY REGISTRAR MAY 8 1967	
Leighton-Durst Funeral Home, Oakland, Md.		25b REGISTRAR'S SIGNATURE John O. Durst	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

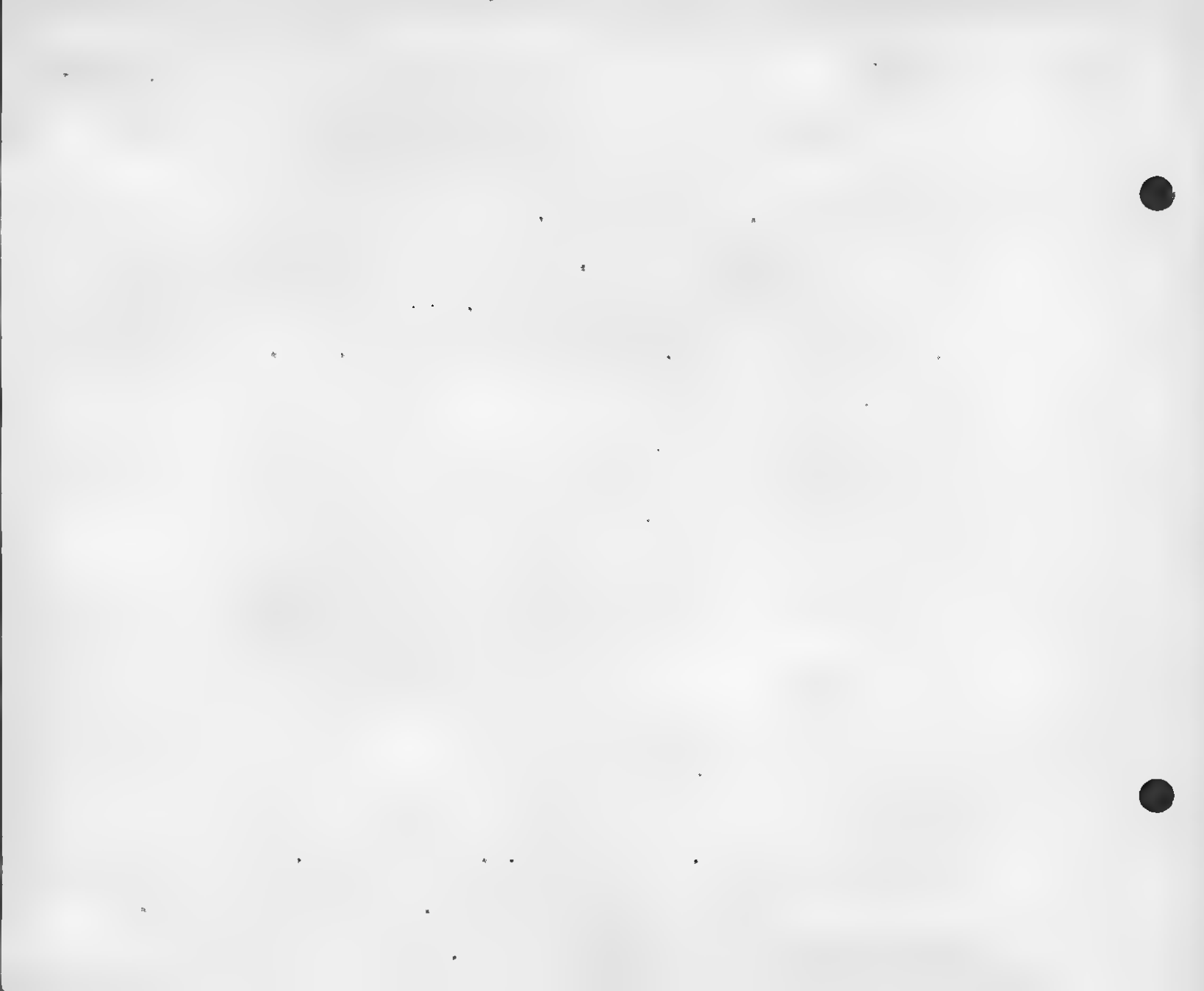
1

CERTIFICATE OF DEATH

06703

06695

1. PLACE OF DEATH a COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Garrett			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c LENGTH OF STAY IN b minutes minutes			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Garrett Co. Memorial Hosp.				d STREET ADDRESS Gortner			
3 NAME OF DECEASED (Type or print) DANIEL L. SWARTZENTRUBER				4 DATE OF DEATH Month May Day 17 Year 1967			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Apr. 28, 1895	
9 AGE (In years and birthday) 72 yrs		F UNDER 1 YEAR Months 19 Days 6 Hours 17 Min 67		10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ret. Farmer		10b KIND OF BUSINESS OR INDUSTRY Gen. Farming	
11 BIRTHPLACE (Country & State, or foreign country) Farquar Co., Va.		12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Lewis J. Swartzentruber		14 MOTHER'S MAIDEN NAME Elizabeth Yoder	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213-24-7275		17 INFORMANT Betty Swartzentruber, R.#2, Oakland		Address (Dau.)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4751 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) " " (c) Arteriosclerotic Cardiovascular Disease				INTERVAL BETWEEN ONSET AND DEATH 3 minutes			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1957 to May 17, 1967 , that (I) (we) last saw the deceased alive on May 10, 1967 , and that death occurred at 4:58 PM , from causes and on the date stated above							
22a SIGNATURE Herbert H. Leighton M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED 15	
22c PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.				22d ADDRESS Oakland, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/20/67		23c NAME OF CEMETERY OR CREMATORY Gortner Union Cem.		23d LOCATION (City or Town) (County) (State) Near Oakland, Md.	
24. FUNERAL DIRECTOR John O. Durst				25a REC'D BY REG. STRAR May 22 1967		25b REG. STRAR'S SIGNATURE John O. Durst	
24. FUNERAL HOME Leighton-Durst Funeral Home, Oakland, Md.				DATE MAY 22 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

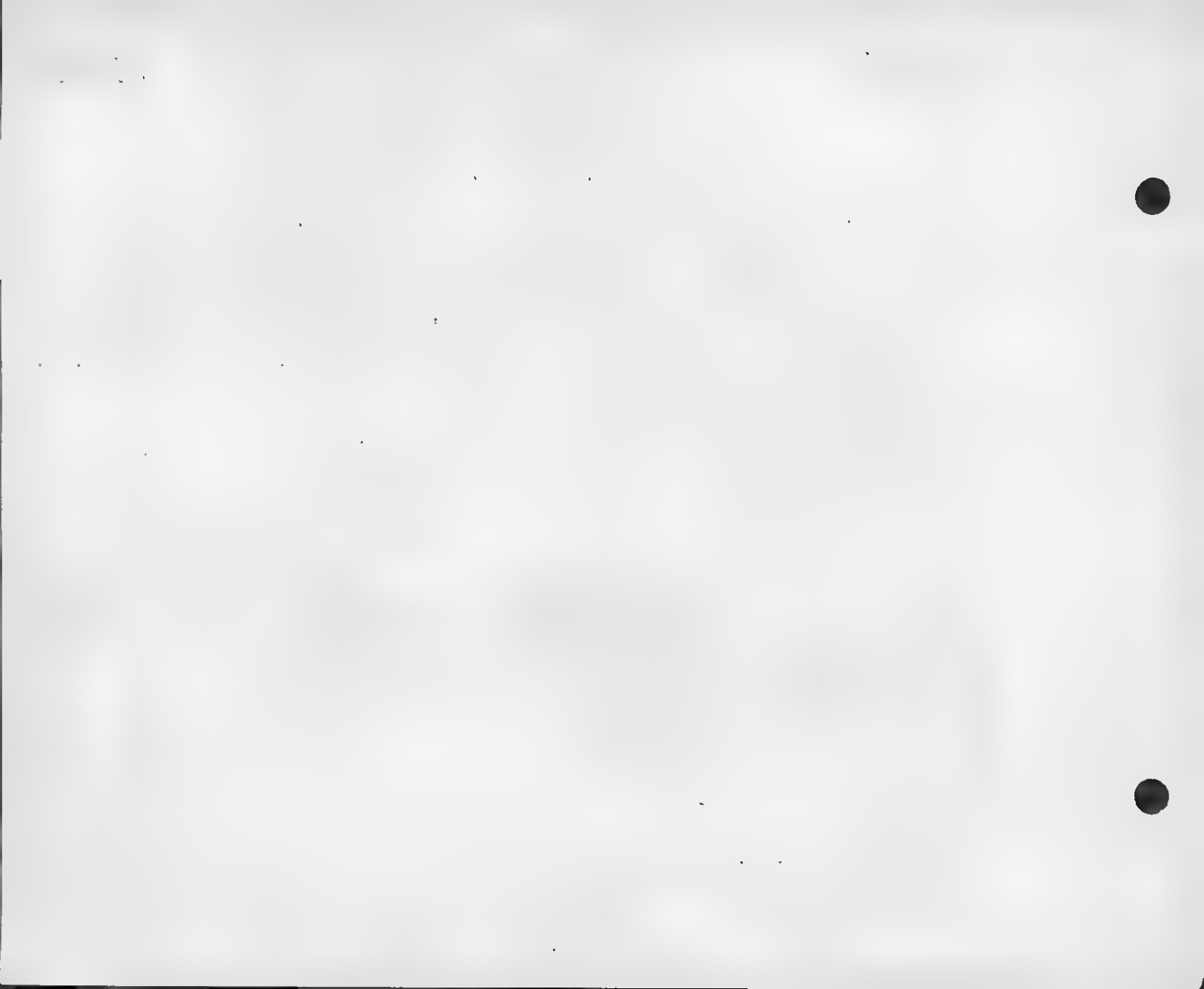
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06710

CERTIFICATE OF DEATH

06696

1 PLACE OF DEATH a. COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 7 hrs.-16 mins. Oakland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. STREET ADDRESS Second St.	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Trembath Last Tinker		4. DATE OF DEATH Month May Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1967
9. AGE (In years last birthday) yrs 7		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Oakland, Garrett, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Tinker		14. MOTHER'S MAIDEN NAME Katherine Randolph Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT William Tinker		Address Oakland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation DUE TO (b) Pulmonary embolism DUE TO (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 12 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 5, 1967 to May 6, 1967 , that (I) (we) last saw the deceased alive on May 6, 1967 , and that death occurred at 5:10 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. H. H. Leighton		22b. DATE SIGNED 7 May 67	
22c. PHYSICIAN'S NAME (Type) Dr. H. H. Leighton		22d. ADDRESS Oakland, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 5/6/67	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION (City or Town) (County) (State) Oakland Md.
24. FUNERAL DIRECTOR Paul D. O'Connell		25a. RECEIVED BY REGISTRAR MAY 15 1967	
ADDRESS Oakland, Maryland		25b. REGISTRAR'S SIGNATURE John L. Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08204

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 15 minutes		d. STREET ADDRESS 4304 Norfolk Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Swallow Falls State Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Melvin Middle Dewayne Last Watson		4. DATE OF DEATH Month 5 Day 30 Year 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-51
9. AGE (In years, last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Werrenton Watson		14. MOTHER'S MAIDEN NAME Marie Powell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 4304	
17. INFORMANT (Father) Werrenton Watson		Address Balto, Md. 4304 Norfolk Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Drowning DUE TO (c) 11			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 929.8 11 2 11 2			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming at Swallow Falls	
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. 5-30-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work State Park	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (Rural) Oakland Garr. Md.		20f. (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		22. DATE SIGNED 6-6-67	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/10/67	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	23d. LOCATION (City or town) (County) (State) Arbutus, Balto., Md.
24. FUNERAL DIRECTOR Leighton-Durst		25. REC'D BY REGISTRAR 9 1967	
25a. ADDRESS Leighton-Durst Funeral Home, Oakland, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06711

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06697

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Deer Park				c. LENGTH OF STAY IN lb Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #1,				d. STREET ADDRESS Route #1,			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LEWIS DALE WHITE				4. DATE OF DEATH Month May Day 19th Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/30/21	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman				10b. KIND OF BUSINESS OR INDUSTRY Pulp wood			
11. BIRTHPLACE (State or foreign country) Garrett Co., Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Lewis White				14. MOTHER'S MAIDEN NAME Alice Jane Harvey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. WW II			
17. INFORMANT Harry White, Rt 1, Deer Park, Md.				Address (Bro.)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9340 IMMEDIATE CAUSE (a) Multiple fractures DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Involved in tornado that struck residence			
20c. TIME OF INJURY Month, Day, Year 8:15 p.m. 5-19-67				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) (County) (State) Rural, Deer Park, Garr. Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md.			
22. DATE SIGNED 5-19-67							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/67		23c. NAME OF CEMETERY OR CREMATORY White Church Cem.		23d. LOCATION (City or Town) (County) (State) Near Oakland, Md.	
24. FUNERAL DIRECTOR Hohn O. Durst Leighton-Durst Funeral Home, Oakland, Md.				25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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